



Mark R. Warner
Governor of Virginia

The Partnership Press

Restructuring the Services System Through Regional Partnership Planning



James S. Reinhard, M.D.
Commissioner

Department of Mental Health, Mental Retardation and Substance Abuse Services
Office of Legislation and Public Relations
 Volume 2, Issue 2 September 2004

WE HAVE A NEW LOOK...

The Department has recently unveiled a new and improved website. The new site complies with accepted standards for accessibility and meets the Level A Conformance to Web Content Accessibility Guidelines 1.0. This is the minimum standard that is required for all state websites. Below is a sample of the new front page. The new website resides at the following address:

<http://www.dmhmrzas.virginia.gov>

If you are visiting the new website for the first time or if you are having difficulty accessing the new website and you continue to see the old site, you may need to hit your browser's refresh button or the F5 key.

There are a few new features already in use on the new site, including a general search feature. You may now search the entire site for specific items or key words (see Search Box arrow below). In addition, you may also search the site for specific forms. You may now search for the forms you need through selecting the office associated with the form or by searching for the title of the form.

A new "breadcrumb" feature allows you to keep track of where you are on the site. As you navigate through the site, you can monitor your current location by looking at your "breadcrumbs" in the black box located below the blue header box (see Breadcrumb Navigation Tool arrow below).

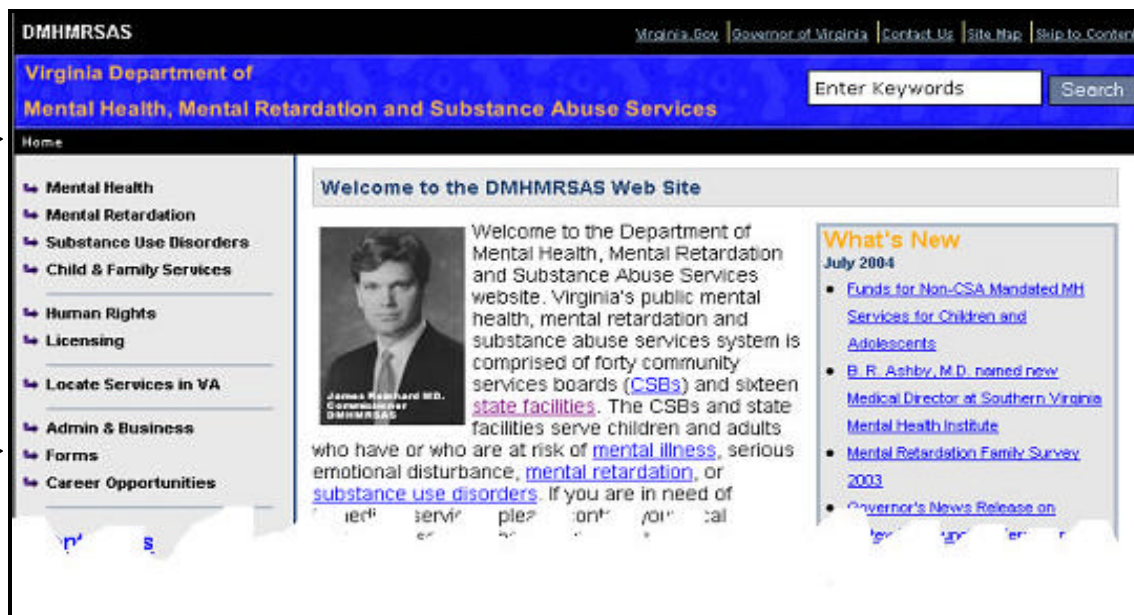
One other new feature available on the website is an event calendar. To access the event calendar, click on "Admin & Business" on the menu bar. You may also sort the calendar events by date, time, title, location or contact name.

Finally, please let us know what you think! At the bottom of each web page is a link to the DMHMRSAS Webmaster. We hope to hear from you!

Search
Box

Breadcrumb
Navigation
Tool

Forms
Search



Commissioner's Column

By James S. Reinhard, M.D.

During a presentation to the Governor on August 19th, I outlined the remarkable way stakeholders in our system are responding to requests from our agency to come together to formulate regional plans for the future. Governor Warner was complimentary of this partnership approach to strategic planning. Regions and special population work groups, based on their own unique characteristics and needs, have been encouraged to submit plans about what they think our service system should look like and what direction we should be heading. (An integration of these plans is underway as we head towards the Governor's Conference December 9 and 10 in Richmond and the next budget and General Assembly session.) This approach is in sharp contrast to previously used methods of administratively dictating what will happen to our system. Plans for our system that are forced upon stakeholders without their involvement and input have been failures.

In Central Office, changes in our "corporate culture" call for our agency to:

- Have a **hopeful** and positive approach to our system, trusting that administrators, providers, family members and individuals being served have the experience, training, and therefore know what is best for our system and its future.
- **Empower** more people throughout the organization to make decisions closest to where the issue is or where the service is provided.
- Promote ownership and shared **responsibility** among our partners for stewardship of our valuable resources.

The agency's cultural changes parallel the concepts of "Recovery, Self-determination, Empowerment and Resiliency" that are getting a lot of attention nationwide, and are included in the Department's vision. These concepts are characterized by:

- **Hopefulness** rather than despair in approaching the illness or disability.
- Encouragement for individuals to be more **empowered**, tell their stories, and see themselves as more than just their illness or disability. Community integration, family, friends, employment, housing and recreation are examples of areas that can ultimately overshadow previously "all-consuming" illnesses and disabilities.
- Promotion of individual and family **responsibility** for finding solutions to difficulties, but not the causes of their illness or disability.

We are clear that shared ownership and responsibility with our partners both inside and outside our agency does not mean an abdication of responsibility in Central Office. We believe it requires us to take an even stronger leadership role in developing clear policy. We believe it requires even more work and effort on our part to promote this cultural change of shared responsibility, and creativity to develop environments with incentives to excel - as opposed to the work required in a culture where forcing compliance and demanding accountability is the major focus.

We are excited about working with our partners, and the leadership of all parts of our service system, to continue to promote these parallel cultural changes of empowerment throughout our organizations and recovery, empowerment, self-determination and resiliency in the people that we serve.

SAVE THE DATE • SAVE THE DATE • SAVE THE DATE • SAVE THE DATE

Plans are currently underway for a statewide Governor's Conference

December 9-10, 2004

Richmond Sheraton West Hotel

Watch your e-mail and mailbox for more details!

Regional Updates

Central Region (Richmond–Metro Area)

Regional Activities: The Crisis Stabilization Unit (CSU) that became operational in October, 2003, provided services to 56 consumers during the fourth quarter. This brings the total served by the program to 137 since program inception. The average length of stay is 5.45 days through June 30, 2004. The program has provided services to all local CSB/BHA's except for Goochland-Powhatan. The distribution of this use is as follows:

Chesterfield	4.1%
Crossroads	2.8%
District 19	7.6%
Hanover	4.1%
Henrico	31.3%
RBHA	50.0%

It appears that geographical distance is a critical factor in the use of the program. We are considering ways to increase accessibility to the outline areas. The CSU was the focus of an article in the *Richmond Times-Dispatch* on July 8, 2004. Finally, near the end of the quarter, the program director at CSU resigned her position. Her duties will be temporarily assumed by the licensed nurse practitioner who has been associated with the program since it's inception. We do not anticipate any reduction in services as a result of this change, but we will monitor developments closely.

The psychologist for the regional jail team (Dr. Lynda Hyatt) has been hired and has begun her duties. The Memorandum of Agreement has been completed and signed by the Riverside Regional Jail and the MOA with the Richmond City Jail is being reviewed by the City Attorneys. The psychiatrist (Dr. Dafferlin DuPree), who will be contracted from Central State Hospital, has been selected and began work on August 16. One of the clinician positions has been offered and accepted and she (Monica Powell) began on August 2. Dr. Hyatt has already provided evaluation services to inmates at the Riverside jail.

A Memorandum of Agreement has been signed with Virginia Commonwealth University to provide the regional behavior team service. Interviews for the psychologist have been scheduled and applicants for the clinician are being screened.

We are awaiting the report of the consultants who visited the region on June 29 & 30. The spent time with staff of Central State Hospital, Richmond Community Hospital (a follow-up meeting is scheduled for July 19 with RCH and CSH staff), Lucy Corr Village and Piedmont Geriatric Hospital. In addition, the consultants were able to meet with the Geriatric Special Populations Work Group of the Restructuring Initiative to gather a state-wide perspective on needs and solutions for this population. Meanwhile, two of the original group identified as needing nursing home services have been successfully placed utilizing Specialized Individual Services funding (see below).

Finally, there have now been four successful placements (including the two mentioned above) utilizing the Specialized Individual Services funding. One of the four has moved to Waiver funding, the other three are receiving on-going services through the Reinvestment Initiative.

The Region IV Partnership Planning Steering Committee continues to meet about twice a month. The focus has been on defining regional restructuring projects and addressing the components requested in the recently received Commissioner's guidance package. The group is working with a consultant to draft a final version of its report and to support that report with appropriate data. A strong level of consensus characterizes the group's deliberations in identifying strengths of the current system as well as opportunities for improvements and enhancements. A final report has been submitted to the Commissioner.

Regional Updates (continued)

Far Southwestern Region (Southwestern Virginia)

Reinvestment and Restructuring: The Far Southwest Region has initiated an Inpatient Purchase of Service (POS) project thanks to a small investment from the Department. This pilot POS targets consumers in four of our six CSBs and involves two of the 4 private psychiatric facilities in our region. The pilot began on July 1st, 2004 and our Transitions Workgroup will take on the role of Regional Utilization Group, meeting on a weekly basis to evaluate utilization and review clinical information for further authorization. Admission diversion from the Institute will occur when the acute admissions units have a total census above 52. Communication from the Institute to the ES Directors will notify them of changes at this target level. The ES Prescriber can initially authorize short-term diversions for a period of up to 4 days. If there is a continued need for acute treatment to resolve admission crisis or stressors an additional 1-4 days can be approved by the MH Director of the referring CSB. As with other POS projects, consumers will only be admitted to the project after an initial TDO period and must meet commitment criteria that would normally result in an admission at the Institute. Even though this small investment may only purchase 233 bed days, we are excited by the opportunity to start this project and are appreciative of the Department's support of our efforts.

With the General Assembly's recent budget we were very pleased to see the investments made in Community based waiver programs, Medicaid increases and the funds allocated for DAP-PACT-POS projects. Having completed the Regional Submission for FY05-06 DAP-PACT-POS Funds we have continued this process of identifying consumers that could benefit from an allocation of these funds. Just as in our submission, we are preparing plans and interventions that are based on our consumers & regional needs. Again we are grateful for the collaborative spirit of the Department in preparing this submission and their willingness to provide the raw data used in our report. In basing our submission request on needs of consumers, it is significant to note that our rate of SMI Adults per 100,000 populations is almost twice the state average. Yet the amounts of combined DAP-PACT funds received in our region per SMI adult is 70% of the state average and much less than that in some Restructuring Planning Regions. The high rate of admissions at the Institute is countered by its very short average LOS and the high number of initial (or 2nd) admissions of consumers. Data from the Department has supported what we have known, experientially, that we have a distinct gap in our community-based infrastructure to address sub-acute or transitional services. DAP-PACT-POS projects are a step in the right direction. Our submission request is based on our region's documented needs and we have faith that Department will encumber these funds based on consumers needs for services.

An Educational project by the MR/MI program, Pathways, at the SWVTC has produced a laypersons pamphlet for the dually-diagnosed. This will be made available at all of our CSB information sites and in both local facilities. Direct care in-services are being planned to increase awareness and interventional skills for community & facility staff.

Regional Partnership Planning: The Southwest Virginia Behavioral Health Board has elected new officers per its charter. E.W. Cline Jr., Executive Director Mt. Rogers CSB will be the Chair and Ron Allison, Executive Director Cumberland Mountain CS will be the Vice-Chair. Their two-year appointments began July 1st 2004. The Board would like to publicly express appreciation to Dale Woods and Sam Dillon for their success in serving as Chair and Vice-Chair for the previous two years. The decision by the Department to fund Project Management for another year is seen as a vote of confidence for our regional efforts. Our Strategic Planning Report has been completed and will be presented at community forums for stakeholder feedback on our initiatives, proposals and goals. The Strategic Planning Report could be summarized by saying that our goals in Restructuring the MH/MR/SA system are focused on **Investment** rather than Reinvestment. We are committed to

Regional Updates (continued)

the principle of Restructuring the mental health delivery system, but we will not reduce service capacity at the Institute until we are assured that consumers have access to community based services that are timely, cost-effective and represent a positive alternative to inpatient treatment at SWVMHI.

Our Transitions to Reinvestment Workgroup has ramped up the frequency of our meetings to better assess utilization of our pilot POS project and impact on the Institute. Staff from the SWVMHI, SWVTC and local CSBs met recently with a representative from the Virginia Senate Finance Committee as part of an orientation to the far SW region. Regional cultural and economic trends, challenges in providing treatment in community settings and challenges faced by our state facilities were discussed.

The pilot for the Virtual Private Network is proceeding in our region and in the Northern Restructuring Planning Region. Discharge Planners and hospital liaisons are excited by this new opportunity and it is hoped that an encrypted network may allow enhanced access in the future for a regionally focused UR that could be potentiated by this level secure access at multiple locations, simultaneously.

Northwestern Region (Valley and Northwestern Virginia)

At the end of fiscal year 2004, HPR I discharged 35 patients from Western State Hospital each of whom had individualized treatment plans for services in the community. Services included supervised residential, substance abuse treatment for those with dual diagnosis, community supports, etc. The cost of those plans for FY '04 was approximately \$1,141,998. These 35 discharges resulted in closing a unit at Western State Hospital and investing those dollars into community care.

Because not all patients required an annual expenditure during 2004, the region was able to use approximately \$233,000 to purchase acute care beds to assist in census management at WSH. Contracts with private hospitals were in place by April, and between April and July, the region bought 197 bed days for 44 patients spending a total of \$108,350. These beds were purchased for indigent patients on a TDO only after a bed at Western State Hospital was determined to be unavailable. The region purchased up to six bed days for each person. At the end of the authorized stay, 31 patients were discharged and 13 were transferred to WSH.

In January the region began the development and implementation of a utilization management program. This includes a protocol for using funds to purchase a bed from a private hospital, a process for authorization for bed days, and specifies the role of CSBs and hospitals in discharge planning from both private and public facilities. This aspect of regional activities is evolving and is being managed by the region's Directors who responsible for mental health services.



TAKE NOTE: DMHMRSAS Central Office staff have new e-mail addresses effective immediately! (Messages to old addresses will be forwarded for a period of time, but please update your contact books now.) New addresses follow this model:
firstname.lastname@co.dmhmrzas.virginia.gov

Regional Updates (continued)

Catawba Region (Roanoke Area)

The Catawba Leadership Team has been meeting extensively to review and update its vision for the Catawba Region System of Care for People with Mental Disabilities. The Leadership met for an all-day meeting July 9th to focus on updating the consensus on our Vision, team membership/commitment and regional strengths and barriers. A second half-day meeting later in July focused on specific objectives and plans. The outcome is intended to be a clear blueprint for the coming year and will clearly define the tasks of the Project Manager. The Regional Leadership Team continues to be composed of representatives from public and private providers including the following:

Diane Kelly, Mental Health Association of Roanoke Valley
Paula Mitchell, Vice-President, Lewis-Gale Medical Center
June Poe and Charles Wohlford, NAMI-RV
Joe Sargeant, Executive Director of Alleghany-Highlands CSB
Rick Seidel, Director, Clinical Programs, Carilion Behavioral Health
Jim Sikkema, Executive Director of Blue Ridge Behavioral Healthcare
Jack Wood, CEO of Catawba Hospital

Staff: Helen Ardan, BRBH, and Walton Mitchell, Catawba Hospital

The Leadership Team updated and revised the restructuring plan submitted in August, 2003. One of the objectives in the first year plan was to establish a community-based aftercare pharmacy for regional consumers who qualify for that service. The original plan was to base the pharmacy within BRBH and have Catawba pharmacy oversight. An alternate, more comprehensive and cost effective proposal was developed and adopted which will create a partnership between Blue Ridge Behavioral Healthcare and the Roanoke City Health Department. The pharmacy will be in the Health Department and, in addition to providing medications, will increase knowledge and access to primary care resources for consumers. The community-based pharmacy will also enable consumers to have access to a single formulary. Discussions have taken place with the State Department of Health and DMHMRSAS to finalize certain financial and staffing elements necessary to implement the project. The new psychosocial program slated to begin operation at Catawba Hospital is in its final planning stages.

Eastern Region (Tidewater Area)

Highlights from the Eastern Region:

- Closed 43 acute admissions beds at ESH in November 2003
- Entered into contracts with Riverside Behavioral Health Center, Maryview Behavioral Medicine Center, and Virginia Beach Psychiatric Center
- Unduplicated Number of Individuals Served (11/15/2003 to 6/30/2004) - 958
Many of these individuals are new to the public services system
- Project Mean Census - Just under 30 (27.93)
- Project Average Length of Stay - 5.66 days
- A Regional Authorization Committee is working efficiently and cooperatively, with good communication among the CSBs, ESH, and the contract hospitals
- Issues:
 - Lack of available nursing home beds for geriatric patients currently at ESH
 - Need to increase the array and availability of SA and MH sub-acute services

Regional Updates (continued)

Northern Region (Northern Virginia)

Additional information regarding the activities in Northern Virginia can be obtained by going to the Partnership website at <http://www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm>.

HPR II completed the second phase of the Northern Virginia Regional Strategic Planning Project and forwarded our strategic plan and recommendations to the Commissioner. This report represents the continued commitment and collaborative work that has distinguished the partners who have come together to address regional service system challenges and improvement opportunities. These partners have included consumers, family members, public and private providers in community based as well as inpatient service settings. In addition to these partners, over the past year, the regional work has come to the attention of other community groups with interests in health planning. These groups have requested and received periodic updates on our work and have shared their own perspectives of some of the challenges in today's environment. The full report can be accessed through the partnership website: <http://www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm> near the bottom of the page. You can access the report directly at <http://www.fairfaxcounty.gov/service/csb/region/Report/NVRSPP-2004-Report.pdf>.

We are grateful for the contributions of all of our regional partners, to our consultant, Joan Durman who organized and wrote most of the report, and to Lara Larson of the Fairfax Falls Church Community Services Board who provided nearly all the infrastructure support throughout the year.

Seventeen recommendations for state-level action were forwarded to the Commissioner. Recommendations involved the need to maintain adequate service capacity through fully funding the continuum of care and medications, addressing issues associated with reimbursement in order to support the continued involvement of private providers, and maintaining the current bed capacity at NVMHI. Additional recommendations included those designed to enhance consumer and family involvement in the services system, to address the service needs of older adults and those with a dual diagnosis of mental illness and mental retardation, and to establish NVMHI as a Center of Excellence in the prevention and management of behavioral emergencies without use of seclusion and restraint.

The region refined a structure to support the continued broad based involvement of multiple partners in the upcoming year. The region will continue to focus on service needs of adults with mental illness and to enhance collaborative work among state facilities, CSBs and private providers. However, we have also determined that we will add workgroups designed to examine and address service issues associated with children and youth as well as older adults.

Consistent with the regional commitment to the full integration of Recovery principles, the region sponsor a conference on September 14, 2004. The conference, "Growing Recovery", was held at the Ernst Community Cultural Center, at the Northern Virginia Community College, Annandale Campus.

We are eagerly looking forward to participation in the Commissioner's conference in December. This opportunity will enable us to celebrate the steps taken and prepare for the opportunities that await us as we strive to realize the Commissioner's vision for a truly transformed services system.

Forensics Special Population Workgroup Update

Workgroup Membership:

Virginia Association of Community Services Boards, Virginia Sheriffs Association, Virginia Association of Regional Jails, Virginia Department of Corrections, Dept. of Criminal Justice Services Supreme Court of Virginia, Virginia Department of Mental Health Mental Retardation & Substance Abuse Services, NAMI Virginia, Commonwealth's Attorneys Service Council, Public Defenders Commission, The Institute of Law, Psychiatry and Public Policy, Office of the Attorney General of Virginia

Forensic Workgroup Goals:

- Prevention of unnecessary arrest, incarceration and prosecution of mentally ill citizens
- Enhanced availability of community-based evaluation and treatment services, in lieu of hospitalization
- Reduction/Elimination of waiting lists for necessary admissions to state MH facilities
- Explore viability of jails as treatment sites

SJR 97/Behavioral Healthcare Subcommittee & Forensic Work Group: Common Themes:

- Development of Jail Diversion Programs
 1. Mental Health Courts
 2. Crisis Intervention Teams
 3. Cross-training for law enforcement and Mental Health personnel
- Improved Service Provision in Hospitals and Jails
 1. Consideration of regionalized facilities for mental health care
 2. Address feasibility of sited or traveling mental health team
- Enhanced treatment access on release from jail

Basic Approaches to Change:

The forensic workgroup has considered an array of diversion and system change components:

- Pre-arrest diversion
- Pretrial diversion methods
- Enhanced care during incarceration
- Improved placement and aftercare
- Cross-training of all agents in the system

Three Components to Address in Changing Virginia's System:

- Explore options for jail diversion
PACT; Crisis Intervention; Pre-arrest; Mental Health Courts
- Improved access to inpatient care; Eliminate long wait times for admissions
Improved post-hospital services (jail or community)
- Enhanced jail-based services
Full on-site mental health/substance abuse services; Therapeutic communities;
Enhanced consultation; Traveling Teams

Geriatric Special Population Workgroup Update

Improvement Initiatives for 2004-2005

The team has planned five projects to be implemented during 2004-2005, to the extent that funding is available:

1) A Beacons Program

This effort will identify and recognize examples of model programs or program components operating in Virginia. The programs will be acknowledged and promoted.

1) Educational Program for Physicians

An educational program will be prepared, in coordination with appropriate coordinating agencies and professional organizations, to reach primary care physicians and geriatric specialists who treat geriatric consumers. Support for the program will be arranged with the commissioner's office.

1) Compilation of Training Resources

Training resources that can be accessed by providers, consumers, and families will be compiled and organized by region.

1) Compilation of Geriatric Services

A directory of geriatric services will be compiled and organized by region. This will include descriptive information about the services, and information on entitlements and how to access services.

1) Obtaining Data for Planning

We will review existing databases that could be useful in planning geriatric services, and extract preliminary data for use by the Geriatric Team.

Problems with Current Services, and General Recommendations

The Geriatric Team developed a list of nine major problems with the current system of services, including the fact that geriatrics is largely an under-served, under-studied, and under-prioritized population, and that little data is available for planning geriatric services.

The team developed a list of fourteen general recommendations for strengthening the system of geriatric services. These range from developing a master plan for geriatric services, to providing adequate community-based resources, to maintaining state hospital beds, to adopting model programs, to making best use of Medicaid and other funding.

Communication with Regional Restructuring Teams

The Geriatric Team recognizes the importance of working with the Regional teams, and plans to send representatives to meet with those teams during the upcoming year. This will include conveying information about needed geriatric services, learning about regional needs for geriatric services, developing efficient ways to communicate with the teams on a continuing basis, and working collaboratively to address needs of geriatric consumers.

For more information, please contact either of the following:

Dr. Bob Lewis Tel. (434) 767-4458 email blewis@pgh.state.va.us

Mr. George Braunstein Tel. (804) 768-7220 email BraunsteinG@Chesterfield.gov

Mr. Will Pierce Tel. (434) 767-4414 email wpierce@pgh.state.va.us

Child & Adolescent Special Population Workgroup Update

For nearly three years, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) along with its Restructuring Policy Advisory Committee has been reviewing ways to restructure and improve services to Virginia's citizens requiring behavioral health interventions. In June 2003, James Reinhard, MD, Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services formed five special population workgroups to look at specific service needs for each population. One of the special population workgroups focused on the behavioral healthcare needs of children, adolescents, and their families. The task of the workgroup was to develop a set of short and long term recommendations on how the behavioral healthcare system for children and adolescents might be strengthened. Membership in this group included parents, youth, advocates, and private and public service providers.

The Workgroup looked at the strengths and weaknesses of the current behavioral healthcare system for children and adolescents in Virginia. It then explored model child behavioral health systems and programs across the country in order to develop a clear understanding about what works and what doesn't. The workgroup determined that the "System of Care" model seemed to have the most consistent success across these programs. The important values promoted by the System of Care are that behavioral health services must be child-centered, family-focused, community-based, culturally-competent, and integrated across agencies. In order for children and their families to receive the best care possible, systems in the community must be streamlined and working together collaboratively.

The workgroup found that Virginia was innovative in the 1990s when it implemented the Comprehensive Services Act (CSA) that set the framework for collaboration in children's services across agencies. However, for a number of varied reasons, children with behavioral health needs sometimes do not receive the services they need.

To address these needs, the workgroup recommends that: 1) Virginia DMHMRSAS adopt the System of Care model for children with behavioral health disorders and promulgate it across all child service stakeholders including families, CSBs, and other public and private providers and agencies; 2) the state funds four "demonstration projects" to implement and research system of care approaches in Virginia; 3) the state funds behavioral healthcare services to children and adolescents in local detention centers; 4) the state builds capacity for child and adolescent behavioral health services by increasing Medicaid rates for day treatment, funding substance abuse services through Medicaid, expanding community-based services, and providing training for professionals serving children.

The goal of these recommendations is to develop a service system in which families and children can gain access to the services they need when they need them. The workgroup established this vision: "The Virginia mental health, mental retardation, and substance abuse services system will provide seamless access to prevention and intervention services for children and their families that promotes the well-being of children and adolescents and reduces the incidence and severity of behavioral health problems." To accomplish this vision, there must be agency collaboration, significant family and youth involvement, an adequate amount of services in each locality, sufficient funding, seamless access to services, and an adequate number of qualified professionals.

These recommendations will be reviewed by the DMHMRSAS and the Restructuring Policy Advisory Committee and will be included, as appropriate, in long term DMHMRSAS planning.

Mental Retardation Special Population Workgroup Update

In support of the overall vision of the Mental Health, Mental Retardation and Substance Abuse Services System, the MR Special Population Workgroup established its' mission statement as follows:

Mission Statement

Rebalance Virginia's service system to become more individually focused where people receive services in the community, based on their individualized needs regardless of funding source. This will be accomplished by building capacity for those persons with all levels of developmental disabilities inclusive of co-occurring conditions, which are funded in a manner that is consistent with the values of self-determination.

To better manage overall Workgroup activities, four (4) subcommittees were established: Steering Subcommittee, Database Subcommittee, Dual Diagnosis Subcommittee, and Case Management Subcommittee. The Case Management Subcommittee was created at the specific request of DMHMRSAS to represent mental retardation issues as part of a collaborative group of case management committees from mental health and substance abuse services. The focus is to develop recommendations for statewide best practices in case management. The Database Subcommittee's focus is the design, development and implementation of statewide databases in three (3) areas: community providers, client profiles, and service needs. In cooperation with the Offices of Mental Retardation and Licensure and the Virginia Network of Private Providers, the development and implementation of a statewide community provider database and developmental disability client profile database are priorities. The Dual Diagnosis Subcommittee fully supports the issues and recommendations made in the report of the Northern Virginia MR/MI Workgroup dated July 30, 2003, however, the current Subcommittee has focused its' priorities on education, training and consultation services.

The MR Special Population Workgroup developed a long list of short-term and long-term objectives for restructuring Virginia's mental retardation/developmental disabilities service system. Through facilitation and consensus the Workgroup prioritized five (5) short-term recommendations for submission to the Commissioner's Restructuring Policy Advisory Committee (RPAC). Each prioritized short-term recommendation provides specific actions steps in the areas of Policy, Administration, Appropriations, and Services. Long-term objectives and priorities have taken somewhat longer to prioritize and will be finalized in the coming months.

The five (5) short-term recommendations submitted to the Commissioner's Restructuring Policy Advisory Committee (RPAC) were:

RECOMMENDATION #1: Provide training to increase the expertise of community professionals and paraprofessionals to ensure that service providers have the knowledge, skills, and abilities to address current client needs, evolving complexity of client care, and the decreasing skills of the available workforce for entry-level client care positions.

RECOMMENDATION #2: Develop policies that do not have a negative financial impact on community private providers when clients need temporary out-of-home placements (e.g., hospitalization) or spend time with family to sustain relationships. Recognize that funding the individual includes, and requires, that the person have stable housing.

RECOMMENDATION #3: DMHMRSAS request increased funding for community services each year, specifically related to maintenance of current services (e.g., utilization, inflation, and COLA) and expansion of services.

RECOMMENDATION #4: Create a statewide database that matches needed supports of persons with developmental disabilities with qualified providers. This database will be also used for planning future service needs and funding requests.

RECOMMENDATION #5: Improve overall funding to promote and reward best practice support strategies for all staff in order to increase stability of direct support professionals through:

- Training, development, and credentialing
- Tax credits to employers and providers
- Staff salaries and benefits that reflect regional economic and other environmental factors (e.g., job competition, workforce availability, cultural diversity, etc.)

Regional Leadership

Central Region:

George Braunstein, Executive Director
Chesterfield CSB
braunsteing@chesterfield.gov 804-768-7220

Charles Davis, M.D., Director
Central State Hospital
cdavis@csh.state.va.us 804-524-7373

Arnold Woodruff, Project Manager
Region IV Reinvestment Initiative
woodruffa@rbha.org 804-819-4187

Catawba Area:

S. James Sikkema, Executive Director
Blue Ridge Behavioral Healthcare
jsikkema@brbh.org 540-345-9841

Jack L. Wood, Director
Catawba Hospital
jwood@catawba.state.va.us 540-375-4201

Northwestern Region:

Jack W. Barber, M.D., Director
Western State Hospital
jbarber@wsh.state.va.us 540-332-8200

Charlotte V. McNulty, Executive Director
Harrisonburg-Rockingham CSB
cmcnul@hrscsb.org 540-434-1941

Eastern Region:

John Favret, Director
Eastern State Hospital
jfavret@esh.state.va.us 757-253-5241

Candace Waller, Executive Director
Chesapeake CSB
cwaller@chesapeakecsb.net 757-547-9334

Scott Elmer, Project Manager
Hampton-Newport News CSB
Selmer@hnnscsb.org 757-245-0217

Northern Region:

James A. Thur, Executive Director
Fairfax-Falls Church Community Services
jthur2@co.fairfax.va.us 703-324-7000

Lynn DeLacy, Director
Northern Virginia Mental Health Institute
ldelacy@nvmhi.state.va.us 703-207-7110

Southern Region:

Jules Modlinski, Ph.D., Executive Director
Southside Community Services Board
jmodlinski@sscsb.org 434-572-6916

David Lyon, Director
Southern Virginia Mental Health Institute
dlyon@svmhi.state.va.us 434-773-4230

Far Southwestern Region:

Derek Burton, RN, Project Manager
SWVA Behavioral Health Board
derekb@mrscsb.state.va.us 276-223-3242

Cynthia McClure, Ph.D., Director
Southwestern Virginia Mental Health Institute
cmclure@swvmhi.state.va.us 276-783-1201

Sam Dillon, Executive Director
Planning District 1 CSB
pd1csb@mounet.com 276-679-5751

Dale Woods, Ed.D., Director
Southwestern Virginia Training Center
dwoods@swvtc.state.va.us 276-728-3121